National Guidelines for

IMPLEMENTATION OF HIV PREVENTION PROGRAMMES FOR FEMALE SEX WORKERS IN NIGERIA

FOREWORD

Nigeria has a mixed HIV epidemic, and the prevalence and transmission dynamics of HIV vary across r egions and populations; some states likely have mostly concentrated epidemics. The 2018 Nigeria AIDS Indicato r and Impact Survey showed that the National HIV prevalence for 15-49-year-olds in the general population is 1.4%. The prevalence is higher among key populations, being as high as 46% for female sex workers and 37% for men who have sex with men in certain locations.

Female sex workers in Nigeria are still at high risk of contracting HIV infection. To reduce this r isk, evidence-informed and human rights-based prevention interventions are a priority national agenda items for f ast-tracking Nigeria's HIV response. It is therefore imperative to efficiently deliver high quality, comprehensi ve HIV prevention programmes to female sex workers.

This document is an update of the previous guidelines published in 2014. It highlights principles, procedures and activities involved in designing and implementing evidence-based HIV prevention programmes for fema le sex workers. It also recognizes that persons with disabilities and adolescents are found among female s ex workers at higher risk of exposure to HIV and therefore, addresses their needs in this revised document. The r evision of the 2014 guidelines is based on new developments, contemporary and emerging issues that are important f or implementing successful female sex workers programmes. The document details the steps and tools nee ded to plan, implement, monitor, scale-up and expand programming for female sex workers, and it includes t ools for monitoring and evaluation. It provides details on the minimum HIV prevention programmes for female sex workers in Nigeria.

The document is intended for use by funders, development partners, non-governmental organisations a nd community-based organisations to guide the design and implementation of high-quality HIV prevention programmes for female sex workers.

The National Agency for the Control of AIDS recognizes the efforts of stakeholders at various level s to control the HIV epidemic. This document is our effort to coordinate the female sex workers HIV prevention progr am in Nigeria in a way that will enable the country to achieve control of the epidemic by 2030.

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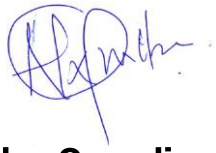
We acknowledge the contribution, dedication and support of the national prevention technical working group (NPTWG) state agencies for the control of AIDS (SACA) and bilateral agencies) and other stakeholders, institutions and individuals for their commitments and inputs to the success of this document

Our gratitude also goes to the entire staff of Community Prevention division and all the relevant divisions and departments of NACA and the lead consultant Prof. Morenike Ukpong for their hard work, assurances and perseverance that steered the development of this guideline.



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Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BBFSW	Brothel-based Female Sex Workers
CBO	Community-based Organisations
CSOs	Civil Society Organisations
FMOH	Federal Ministry of Health
FP	Family Planning
FSWs	Female Sex Workers
HIV	Human Immunodeficiency Virus
IBBSS	Integrated biological and behavioural surveillance survey
IP	Implementing Partners
KP	Key Populations
M&E	Monitoring and Evaluation
MPPI	Minimum Prevention Package of Intervention
NBBFSWs	Non-Brothel-based Female Sex Workers
NACA	National Agency for the Control of AIDS
NAIIS	Nigeria HIV/AIDS Indicator and Impact Survey

NPTWG	National Prevention Technical Working Group
OSS	One Stop Shop
PMTCT	Prevention of Mother to Child Transmission of HIV
SACA	State Agency for the Control of AIDS
SFH	Society for Family Health
STI	Sexually Transmitted Infection
TG	Transgender
UNAIDS	Joint United Nation Program on HIV/AIDS
WHO	World Health Organisation

Chapter 1.0
INTRODUCTION

Nigeria is a federation, made up of 36 states and the Federal Capital Territory (Abuja). The states are grouped into six geo-political zones: North West, North East, North Central, South West, South East, and South South. The national HIV prevalence among the general population in 2018 was estimated to be 1.4% [1], but there are differences across the geopolitical zones -- from 3.1% in South South Nigeria to 0.6% in North West Nigeria. The prevalence is higher among key populations: 19.4% among brothel-based female sex workers (FSWs) and 8.6% among non-brothel based FSWs [2].

A major risk factor for HIV infection among FSWs in Nigeria is their underestimation of the risk of infection. Often, FSWs rationalize, defend, or justify their high-risk behaviors, which is a typical psychological response to worry, threat, and anxiety arising from the discrepancies between beliefs and behaviors. To reduce this dissonance, many FSWs strongly believe in fatalism, predestination, and faith-based invulnerability to HIV infection. They also experience a high level of HIV-related stigma [3]. In addition, non-consistent use of condom and the use of psychoactive drugs increases the risk for HIV infection: brothel based FSWs reported less condom use with boyfriends and casual partners than do non-brothel based FSWs, whereas injection-drug use was reported higher among non-brothel based than among brothel-based FSWs [4]. Sexually transmitted infection also is a risk factor for HIV infection among FSWs, though there is evidence of a decline in the prevalence of syphilis and Trichomonas vaginalis in the study population (but no decline in the prevalence of Neisseria gonorrhoeae infection and bacterial vaginosis) over a six-year study period [5, 6].

FSWs in Nigeria also face violence and abuse, which are structural risk factors for increasing their risk for HIV infection and sexually transmitted infections. FSWs experience economic, physical, sexual and psychological abuses from clients, brothel managers and the police [7, 8], and those with lower educational status are at higher risk of being HIV positive [5].

Two special sub-population of importance whose needs are prioritized in this documents are adolescent and young FSWs and FSWs with disability. It is estimated that about 20 to 40% of female sex workers began selling sex before the age of 18 years [9]. HIV testing opportunities for young FSWs are therefore critical and so systems and structures need to be created to enable them access HIV testing services outside the barriers created in public health institutions that operate age-limits for sexual and reproductive health service delivery.

HIV prevention interventions for FSWs will need to not only address the biological, behavioural and structural risk factor that increase the risk for HIV infection. The interventions must also target the wider population connected to FSWs and their clients. This reality reflects the fact that clients of FSWs can be a bridge for transmission of HIV to the general population. Targeted HIV prevention intervention for FSWs is, therefore, highly needed in Nigeria.

Chapter 2.0
PROFILE OF FEMALE SEX WORKERS

The World Health Organisation defines sex work as the provision of sexual services for money or goods. Sex workers may be women, men or transgendered people who consciously define their activities as income generating even if they do not consider sex work their occupation. FSWs exchange anal, vaginal, and/or oral sex for money or other items of value, primarily with men.

In Nigeria, most sex workers are females, and they are found in all states. While FSW are usually grouped as brothel and non-brothel based, this characterization is usually inadequate to guide programming. FSW are diverse in age; socio-economic status; frequency and pattern of sex work; setting of sex work (brothel, street, home, bars/nightclubs/casinos, hotels/lodges); price per clientele (high, medium, or low, related to the type of sex act--anal or vaginal); and management structure (work for a pimp or brothel madam).

The operational characteristics (or typologies) of FSWs vary considerably across Nigeria. For example, in Lagos, 40% of FSWs operate through hotels or lodges; 27% in bars, nightclubs, or casinos; 21% in brothels; and 6% public places, where they solicit for clients. In Nassarawa, by contrast, 30% solicit for clients in public places; 30% operate in hotels or lodges; 14% operate in bars, nightclubs, or casinos; and 10% are based in brothels [10]. The difference in the typology of FSWs by state highlights the needs for context- specific design of FSWs programmes. Understanding the operational mix of FSWs in targeted intervention areas helps to improve the quality of service offered to them.

2.1. Brothel-Based Sex Work
Brothel-based sex workers operate from an establishment with rooms that clients and sex workers use for sexual activities; clients visit the brothel and contact the sex workers. The client may use a room at the brothel for sex or take the sex worker to another location. Managers of these brothels sometimes facilitate the sex worker-client interaction and may take a portion of the money the sex worker receives.

2.2. Street -Based Sex Work
Street-based sex work is one of the most common and explicit types of sex work in the country. Here, the sex worker solicits clients on the streets, in car parks, and/or other public places. Sexual services are provided on the side street or in a car, brothel, home, or hotel. Taxi drivers or bar owners may facilitate access to the FSWs, but most operate independently.

2.3. Home-Based Sex Work
Home-based sex work is the exchange of sex for money in one's home. Clients contact sex workers directly and set up appointments to meet them in their homes, or they may visit the homes of known sex workers.

2.4. Venue-Based Sex Work
Venue-based sex workers exchange sex for money in a designated location. They operate from locations such as bars, nightclubs, casinos, and hotels and lodges. Taxi drivers and motorcycle riders often facilitate this type of sex work.

2.5. Internet-Based Sex Work
These are sex workers who solicit for clients online through virtual platforms, such as Baddoo, Tango, Messenger, Instagram, Wechat, Hangout, Hitwe, Palmchat, or Tinder.

2.6. Others

Other typologies where FSWs solicit for clients are hostels, university campuses, escort services, and truck/ trailer stops.

Chapter 3.0
HIV PREVENTION PROGRAM ELEMENTS FOR FEMALE SEX WORKERS

3.1 Principles Guiding the Design and Implementation of HIV Prevention Programmes for Female Sex Workers

3.1.1. *Evidence-based:* Research, evidence, and innovation are critical for effective programme development, including addressing various barriers and strategic expansion of services towards universal coverage. Programmes are expected to be designed after a needs assessment for community members is conducted. All programmes implemented for FSWs are expected to have clearly defined monitoring and evaluations that will facilitate yearly improvement in the programmes.

3.1.2. *Quality-focused and result-oriented*: The design and implementation of HIV prevention programmes for FSWs must meet defined outcomes that accord with the objectives of the national HIV prevention plans. Programmes and services must be implemented with commitment to high quality and cost efficiency.

3.1.3. *Rights-based approach*: All FSWs have the inalienable right to quality HIV prevention services in synergy with other education and development opportunities that contribute to their general health and wellbeing. FSWs also have the right to participate in the development/review, implementation, monitoring and evaluation of this policy and programmes that addresses their HIV risk.

3.1.4. *People-centered approach*: FSWs have diverse needs. This guideline promotes their access to integrated people-centered HIV prevention services, wherein people and communities, not diseases, are the center of planning and implementation. HIV prevention interventions should focus on empowering FSWs, including those that are young and those living with disability, through education and support to take charge of their HIV prevention and risks, rather than being passive recipients of services.

3.1.5. *Integrated services delivery*: HIV prevention programmes for FSWs shall provide biomedical (clinical) and behavioural and structural interventions that address vulnerability to violence, stigma, and discrimination. HIV prevention services will be delivered in ways that ensure that FSWs receive a continuum of care delivered at the facility and community sites (public and private) according to their needs.

3.1.6. *Cost-effective:* The programme should be cost-effective to ensure value for all allocated resources invested in achieving set objectives.

3.1.7. *Context specific*: Interventions should respond effectively to the local HIV epidemic and the needs of local FSWs communities. Cultural needs and values of the communities where the programmes will be implemented should inform the design of programmes. This awareness will foster practices that make the service-delivery environment safe, supportive, and protective for care recipients.

3.2 Key Components of HIV Prevention Programmes for Female Sex Workers

NACA advocates a combination prevention approach that consists of behavioral, biomedical, and structural intervention for FSWs.

3.2.1. *Behavioural interventions* should be offered directly to FSWs by peer educators through outreach programmes and education sessions. These activities should promote access of FSW to male and female condoms, lubricants, sexually transmitted infections and HIV prevention information and education, referral services, human rights education and community-based gender based violence prevention and response activities. Outreaches, which include both physical and virtual activities, should be used to make initial contact with FSWs. At the initial contact, they are connected with specific programmes and services. For FSWs that use drugs, harm reduction information and education should be offered.

3.2.2. *Biomedical interventions:* These include testing and diagnosis of infections, HIV treatment, access to pre-and post-exposure prophylaxis, retention in care, management of sexually transmitted infections, promoting access pre-exposure prophylaxis, viral hepatitis screening, tuberculosis screening and management. Others include access to post-exposure prophylaxis, prevention of mother to child transmission of HIV services and other clinical services that improve the sexual and reproductive health of FSWs including post gender-based violence care. For FSWs that use drugs, harm reduction and drug overdose management services should be offered.

3.2.3. *Structural interventions* address social, political, and environmental systems and beliefs that increase the vulnerability of FSWs. These include law and policy advocacy, providing legal aids including alternative dispute resolution mechanisms, litigation, human rights education. Other structural interventions include economic empowerment, and supporting access to mental health care when needed, provision of safe spaces and vocational skills development including psychosocial support for life-long care. Efforts to address stigma in the community, and mitigate its impact for FSWs is critical for effective community response including community led organizational development and individual capacity strengthening.

The key elements of an HIV prevention Program for FSWs are summarised in Table 1 below and are described in the sections that follow.

Table 1. Key components and elements of the HIV prevention intervention for female sex workers

Key component	**Elements**
Behavioural interventions	• Outreach (physical and virtual) to create awareness about HIV and sexually transmitted infection prevention • Peer education through interpersonal communication to improve understanding on HIV and sexually transmitted infection prevention strategies, human rights, sexuality and risk and harm reduction education, contraceptive information and education, community level mental health screening, gender based violence prevention • Demonstration, promotion, and distribution of male and female condoms and water-based lubricants
Biomedical interventions	• HIV testing services • Testing and treatment of sexually transmitted infections • Access to male and female condoms and water-based lubricants • Linkage and follow up of HIV positive clients to antiretroviral therapy • Access to cervical, anal cancer, hepatitis and tuberculosis screening and management • Access to pre and post-exposure prophylaxis • Access to contraceptive counselling and services • Access to prevention of mother to child transmission of HIV services

	• Access to post gender based violence care • Access to mental health services • Access to psychosocial counselling, support and treatment adherence counselling and services • Access to harm reduction interventions, drug overdose management, rehabilitation services.
Structural interventions	• Vocational and life building skills development • Economic empowerment activities and linkages • Provision of safe spaces and community centers including safe shelters for victims of gender based violence • Community led organizational development and individual capacity strengthening. • Access to legal aid • Capacity building for law enforcement agencies, judiciary and legislature • Capacity building for healthcare workers • Community mobilization and dialogue • Advocacy for creating an enabling environment for interventions • Law and policy advocacy including intra and intercommunity advocacy. • Access to justice through legal aid including but not limited to alternative dispute resolution mechanisms, litigation, human rights education • Referral and linkages service strengthening and expansion

3.3. Referrals and Linkages

The National FSWs HIV prevention programme recognises the complementarity of clinical (biomedical) and non-clinical (behavioural and structural) interventions that can enable FSWs to develop competency for HIV prevention. Projects providing HIV prevention services to FSWs should have systems and structures that promote access of FSWs to clinical and non-clinical services. Community centres that promote FSWs access to non-clinical services should have mechanisms that promote their expedited access to clinical services in public and/or private health facilities. Similarly, health facilities that provide services to FSWs should have linkages with community centres that promote FSWs access to non-clinical services. Projects that establish one-stop-shops should provide both clinical and non-clinical services for FSWs in safe spaces.

All projects implementing HIV prevention programmes should ensure that the location of the community service site is acceptable to the target population of FSWs and that the package of services and the mode of providing services are acceptable to the target population of FSWs. Also, projects should ensure that effective referral and linkage systems are in place to facilitate the use of the services by FSWs. This will require that:

- Appropriate local service providers are identified through community consultations and environmental assessments;
- Mutually supportive relationships exist between the implementing organisation, FSWs and the service providers;
- Effective systems be established for making and tracking referrals and service delivery.

3.4. Adaptation of Minimum Package of Intervention for HIV Prevention Programmes

All projects that provide HIV prevention services to FSWs should provide the minimum package of intervention for HIV prevention as prescribed by these guidelines – a combination of behaviour, biomedical and structural interventions. The content of each package of interventions may differ by local need and availability of ancillary

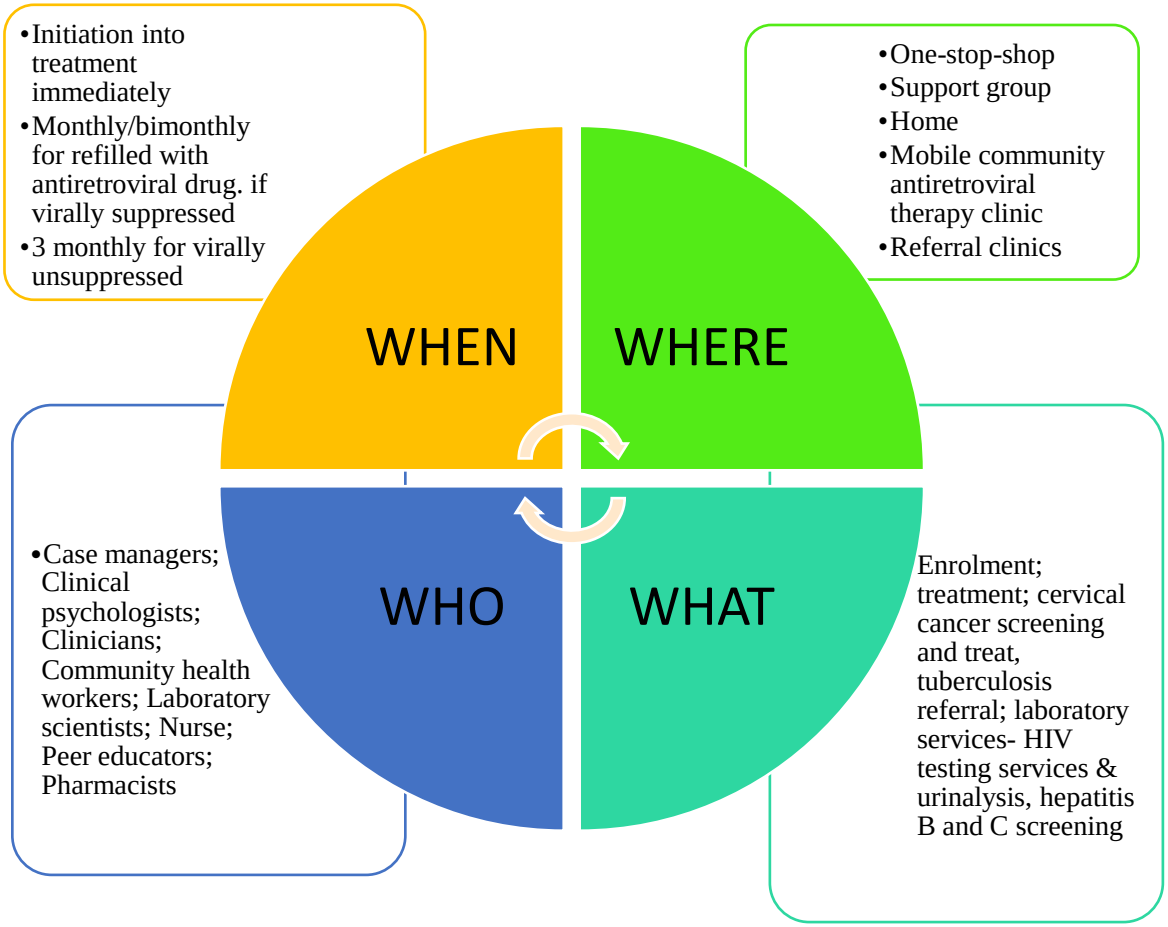
care services The content of the minimum package of intervention for FSWs for any project should be defined in a collaborative, participatory manner with the targeted population of FSWs who will be service recipients.

3.5. The One-Stop-Shop Model of Integrated Service Delivery

The goal of the one-stop-shop model for delivery of services to key populations is an enabling environment that is stigma free, conducive, gender responsive, client friendly and safe for access to comprehensive (biomedical, behavioural and structural) services. It is also expected to provide youth friendly services that enables young FSWs to have access to HIV and sexual and reproductive health services. The community service delivery component of all one-stop-shop should identify the needs of their clients who have disability and adapt the delivery of their services to address these needs.

One-stop-shops are primary health care delivery structures operated by community-based organisations and community members. The shops provide access and coverage of a suite of mutually reinforcing prevention, treatment, care, support and protection services for key populations [11]. Figure 1 provides an overview of the structure for operating clinical (biomedical) interventions are provided in this space only by professionals, though the space can serve as a drop-in centre for medication pick-ups.

Figure 1: A diagrammatic representation of the one-stop-shop service delivery model for key populations



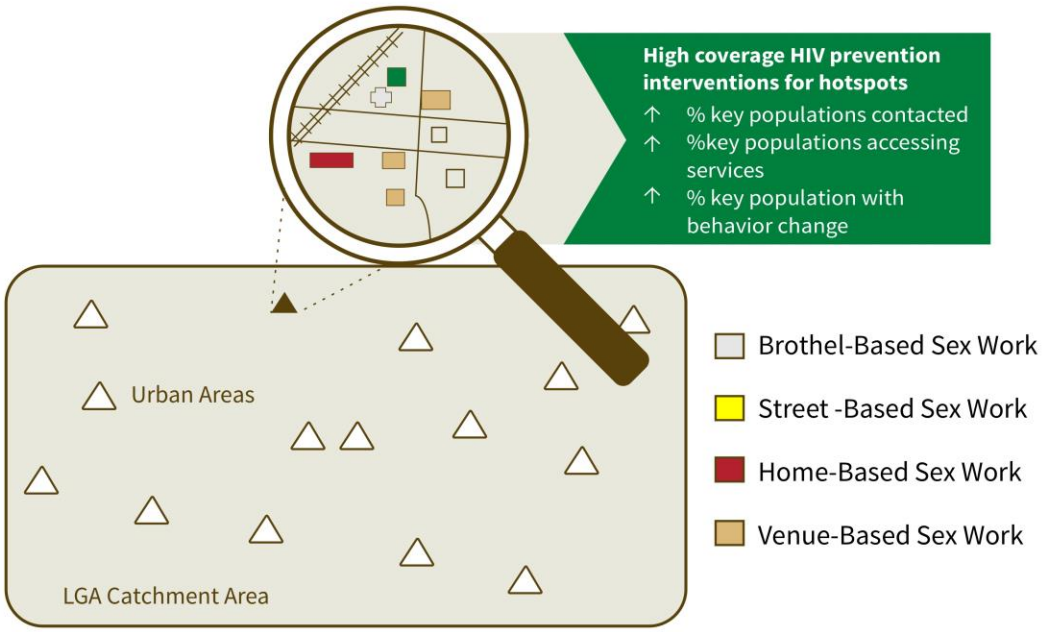
Chapter 4.0
MANAGEMENT OF HIV PREVENTION PROGRAMMES FOR FEMALE SEX WORKERS

4.1 Evidence-informed HIV Prevention Projects for Female Sex Workers

4.1.1 Coverage: HIV prevention programmes for FSWs should aim to reach as many sex workers in targeted clusters as possible. Information about the FSWs can be obtained from the State Agency for the Control of AIDS. The cluster approach to FSWs service delivery aims to improve the predictability, timeliness, and effectiveness of HIV prevention response. It strengthens leadership and accountability and enhance partnerships and complementarity of HIV prevention, treatment and allied service delivery.

When planning a project, the estimated size and typology of FSWs populations at the planned intervention sites should be obtained. Figure 2 is an example of a map showing the areas where various typology of FSWs spend time (these locations are called "hotspots"). Knowing the types of FSWs at the intervention sites enhances the planning and delivery of services that meet their needs. All projects should aim to reach 90% of FSWs in targeted hotspots. Indicators of project success are the number of FSWs who access services and the number who demonstrate behaviour change. Organisations should work with the State Agency for the Control of AIDS to identify strategies for delivery of services to a higher proportion of FSWs in the State.

Figure 2. Cluster Area Approach to HIV Prevention Intervention Design



4.1.2. Micro-Planning: Micro-planning is used to ensure that peer-led outreach is effective and efficient. Appropriate planning and implementation to reach large number of FSWs within hotspots is essential. Micro-planning involves four main stages.

1. **Site load mapping:** Peer-led mapping is used to systematically validate and define hotspots and their logical geographical boundaries.
2. **Spot analysis:** Spot profiling informs the delivery and components of HIV prevention programmes, per peer and per location. A simple tool collates relevant information on locations where FSWs congregate.
3. **Contact mapping/Peer social network analysis:** In each location, the peer educators make a list of FSWs they know, and they compare lists. Decisions are made about which peer educator will take responsibility for outreach, education, and monitoring according to this shared information at (contact mapping).
4. **Registration:** This involves enrolling FSWs into the project. All enrolled FSWs should be profiled according to their demographics and client volume to determine their risk and vulnerability.

Details generated from the micro-planning process help in planning the project activities, one of which is outreaches and peer education. There are community friendly tools with which peer educators can generate and analyse the information about FSWs at hotspots they are in-charge of as "hotspot managers". Seven micro-planning tools have been field-tested for use in Nigeria:

Tool 1: Spot analysis enables participants to compile all the information they have about a hotspot and plan outreach based on the analysis of this information.

Tool 2: Site Load mapping helps participants assess the daily, weekly, and monthly load of sex workers in each of the hotspots.

Tool 3: Condom accessibility and availability mapping benefits participants by disclosing the condom availability points and determining if they are easily accessible to MSM and transgender.

Tool 4: Opportunity gap analysis helps participants understand opportunity gaps in each hotspot, reasons for the gaps, and ways to overcome them.

Tool 5: Contact mapping helps participants map their contacts within the community of sex workers. Based on this understanding, participants select peers and plan outreach activities in all hotspots.

Tool 6: Preference ranking helps identify the reasons for gaps in service uptake by the community and to develop strategies to improve the service levels.

Tool 7: Stakeholder analysis helps participants identify the stakeholders and a careful analysis of the power structures in which MSM and transgender are involved and the people whose support can help create an enabling environment for the programme.

The tools can be classified as tools for:

- Improving the quality of outreach: Spot Analysis, Contact Mapping, and Site Load Mapping
- Improving service delivery: Preference Ranking, Condom Accessibility, and Availability Mapping
- Improving the Program: Opportunity Gap Analysis
- Facilitating the creation of an enabling environment: Stakeholder Analysis

The outcome of the analysis helps "hotspot managers" identify the needs of the FSWs at the hotspot and design interventions to address these needs. Having FSWs design, implement, and monitor the outreach activities increases the appropriateness of the project and FSWs' acceptance of it. The micro-planning process builds the competency of FSWs peer leaders to manage their community, nurture community participation and ownership, and organize individuals into groups for community action. Specific plans for the outreach and peer education activities should be informed by the following factors:

4.1.2.1. Geographical location: Outreaches should be implemented in hotspots where FSWs work. Understanding the typology of the FSWs in those hotspots will inform the design of outreaches and peer education. For example, the bar-based hotspots in cities operate mostly after 4 pm, and activity peaks by 7 pm, so outreaches at those spots are best conducted in evenings.

4.1.2.2. Typology of sex workers: Each typology has unique characteristics and outreach needs. Outreaches to urban FSWs who solicit for clients on the street will require a strong peer network to facilitate tracking of FSWs when they are not on the streets of initial contact. When projects work at venue-based sites, such as bars, brothels, or lodges, the project will require engagement with the managers, who have an upper hand in management decisions.

4.1.2.3. Volume of sex: High-volume FSWs (ten or more clients per week) are more vulnerable and should be given priority over medium-volume (5 to 9 clients per week) and low-volume (4 or fewer clients per week) FSWs.

4.1.2.4. Types of sex: FSWs who engage in unprotected anal sex should be prioritized, as the risk of contracting HIV through unprotected anal sex is 8-9 times higher than through unprotected vaginal sex.

4.1.2.5. Age: Younger FSWs have different concerns and needs than those of older FSWs; whereas younger FSWs are concerned with access to contraception, physical appearance and client load, older FSWs are more concerned with finding economic alternatives to sex work and protecting their children.

4.1.2.6. Disability: The relationship between HIV and disability will receive due attention in this guideline due to the higher risk of exposure of persons with disabilities among all key populations to HIV. People living with HIV may also develop impairments, which hinders their full and effective participation in society on an equal basis with others. The guidelines will prioritse process that facilitates their access to HIV education, information and prevention and gender based violence prevention services; and promote the building of the capacity of service providers to provide disability-friendly services.

4.1.2 7. Vulnerability: History of exposure to violence and consumption of alcohol or drugs increase a FSW's vulnerability to HIV and sexually transmitted infections. FSWs with these histories should be prioritized for interventions.

4.1.3. Outreaches and peer education: Outreaches and peer education are to be led by FSWs. When planning outreaches, consideration should be given to time when FSWs will be available – the typology of the FSW at the hotspot will inform the time FSWs are free from work and are therefore most likely receptive to sensitization, education and mobile clinic activities. Consideration should be given to enabling those who have control over FSWs -- FSWs community leaders, pimps and bar managers – to access outreach information. The relationship of FSWs to other third parties, such as family members, also should be considered in the design and implementation of outreach programmes. Third parties may promote condom use and uptake of referral services, and offer protection against harassment and violence (sexual, physical, and verbal/emotional).

4.2 Program Management and Coordination

4.2.1. National Agency for the Control of AIDS: The National Agency for the Control of AIDS provides oversight function for the national HIV prevention program for FSWs. It coordinates all projects and activities related to HIV prevention in the country. In collaboration with the National HIV Prevention Technical Working Group, it coordinates and monitors the State FSWs HIV prevention programmes. The agency also provides guidance on programme modification and implementation strategies.

4.2.2. Federal/State Ministry of Health: The National/State Agency for the Control of AIDS will collaborate with the Federal/State Ministry of Health to implement the biomedical element of the national HIV prevention programme for FSWs - the logistic management for medication supplies, personnel training, and capacity building for antiretroviral therapy, sexually transmitted infection and pre-exposure prophylaxis management.

4.2.3. State Agency for the Control of AIDS: It is the responsibility of the State Agency for the Control of AIDS, in collaboration with the State Prevention Technical Working Group, to design, coordinate and monitor the State FSWs HIV prevention programme. Partners are expected to develop projects that address components of the prevention programme in ways that ensure adequate coverage and equitable distribution of interventions and that avoid duplication of efforts. Monitoring should include insurance that projects adhere to the national guidelines, and all FSWs HIV prevention programmes provide the minimum standards for quality interventions.

4.2.4. Role of implementing agencies: Non-governmental/community-based organisations that implement HIV prevention programmes for FSWs should submit to the State Agency for the Control of AIDS a project proposal with details on the project implementation. The agencies should ensure that all targeted FSWs receive biomedical, behavioural, and structural interventions as agreed in the contract/proposal. The agencies also should submit quarterly reports on their progress to the State Agency for the Control of AIDS. Additional responsibilities include local problem solving, recruitment of the local team, and setting up of monitoring and evaluation systems, as guided by the State Agency for the Control of AIDS.

4.2.5. Implementation Team: Project-implementation teams should include members with various skills. Composition of the team should be determined by the types of services to be provided, their method of delivery, and the size of the targeted FSWs population. The project should have a programme coordinator responsible for implementation of the programme, an accountant managing the projects' expenses, and a monitoring officer responsible for collating and analyzing the project data and generating reports. The team may also include doctors and nurses to provide the project's biomedical interventions, while the counsellor(s) support the behaviour-change process. The intervention team should also include program officers and peer educator who provide behavioural and structural interventions to a cohort of FSWs.

4.2.5.1. Recruitment of staff: Candidates who are key-population friendly and whose attitudes, knowledge, and experiences will enable them to work successfully with FSWs should be given priority for employment. The candidates should be sensitive to issues of gender, age, disability, sex, and sexuality and be able to deliver services in a non-judgmental manner. Sensitivity to and understanding of the challenges posed by poverty, discrimination, and gender-based violence to FSWs, are essential. Staff members should include FSWs. It is an advantage to also engage staff who are able to address the needs of persons with disability such as the use of sign languages.

4.2.5.2. Establishing roles and responsibilities: The roles and responsibilities of each member of the implementation team should be clearly defined. This policy does not imply that staff cannot exchange the role of each other, but team leaders should clearly communicate changed roles and responsibilities to team members. Team members should be aware of their roles and responsibilities and the line of communication for the project.

4.3. Capacity Building

The capacity of project staff should be built to enable them change-self and facilitate and support risk reduction behaviour(s) of FSWs. Peer educators must have their values clarified and understand the principles guiding the project. Members of the implementation team are expected to ensure that all FSWs recruited for the organisation's project have the knowledge and skills to make FSWs feel empowered and able to "own" the interventions. Staff capacity can be built through classroom training, field exposure, practical sessions, and experiential and

interactive sessions with other FSWs. Training should be conducted in languages best understood by the staff, using methods suited to the cultural ethos and practices of the host communities.

The training should be guided by a nationally standardized curriculum and a training/facilitator's manual. Participants should have reference materials that they can keep for reference at the end of the training. Trained trainers who can adapt the curriculum to the local realities should facilitate the training.

4.4. Data Collection Tools

Appendix A provides the details of the data collection tools for the HIV prevention programme. It also provides details of those expected to collect the data. Further details about the tools can be obtained from the office of the National, Zonal or State offices of the Agency for the control of AIDS.

It is essential that all projects on MSM and transgender in the country keep adequate documentation of their activities. All projects – donor or non-donor funded - are required to submit quarterly reports through the State Agency for the Control of AIDS, to the zonal offices of the National Agency for the Control of AIDS. These data shall be uploaded to the non-health sector data collection platform. Quarter reports should be collated using the non-health sector data reporting tools developed and disseminated by the National Agency for the Control of AIDS.

Chapter 5.0
IMPLEMENTATION OF BEHAVIOURAL HIV PREVENTION PROGRAMMES

5.1 Behavioural Interventions

Behavioural interventions are offered to FSWs and their clients by trained peer educators. The goal is reduced risk of contracting HIV and sexually transmitted infections by FSWs and their clients. Table 2 provides a summary of the behaviour intervention package for FSWs.

Table 2. Programme Behavioural Interventions

Programme Component	Checklist of Activities for Implementation	Tools for data collection
BEHAVIOURAL INTERVENTIONS		
Outreach Interpersonal communication Small group discussions Community stakeholders' meetings **Peer Education:** HIV and sexually transmitted infections' prevention, contraception, human rights, sexuality and risk and harm reduction **Counselling, skills building and referral:** Interpersonal/gender-based violence prevention Mental health screening, psychosocial support	**Entry level:** Identify key stakeholders in the community, such as brothel owners/managers, local pimps, chair ladies, madams, law enforcement agents and others Conduct community stakeholder dialogue Conduct key influencers/ gate keepers pre- intervention dialogue Validation of identified hotspots/intervention sites Selection of peer educators within respective FSWs community. **Intensive Level:** Train employed peer educators Peer educators to conduct monthly outreach to FSWs communities, using drama/role plays, film shows, games Conduct monthly review and refresher meetings with peer educators Conduct quarterly community stakeholders' update meetings Process documentation and dissemination findings using	**Entry level:** Validation-format tool Stakeholder analysis tool Spot analysis tool Mapping by civil society and community-based organisation partners Site load mapping Baseline participatory monitoring and evaluation **Intensive Level:** Peer educators' recruitment criteria tool Peer education plus manual Contact listing by peer educators Community conversation tool kit Peer educator monitoring tool Opportunity Gap Analysis

	drama/role play, community conversation toolkit **Exit level:** Formation of community-led social structures/groups Plan for sustainability of formed social structures/groups Promote voluntary Peer educators from the community End of project evaluation/dissemination Sustainable sexual behaviour programmes	 **Exit level:** Evaluation tool Final reporting template Best practice document Success story documentation Opportunity Gap Analysis
Expected Results and Indicators Percentage of FSWs reached with behavioural education Percentage of FSWs reached with Minimum Prevention Package Intervention		
Condom and Lubricant programming Demonstration, promotion of use, and distribution of male and female condoms and water-based lubricants	**Entry level:** Identify condom and water base lubricant procurement mechanism Estimate condom and water base lubricant requirement for FSWs **Intensive level:** Distribute and track condoms and water base lubricant to FSWs through outreach team Identify traditional/non-traditional outlets and establish distribution systems in all sites **Exit level:** Outlet sustainability of condom and water base lubricant distribution	**Entry level:** Condom and water base lubricant availability mapping Peer educator card Peer education plus manual **Intensive Level:** Condom and water base lubricant accessibility and availability map Condom and water base lubricant distribution tool **Exit level:** Condom and water base lubricant distribution format
Expected Results and Indicators Number of condoms distributed Number of lubricants distributed Percentage of FSWs reporting the use of condoms consistently with clients Percentage of FSWs reporting the use of condoms consistently with regular partners		

5.1.1 Qualities of a FSWs peer educator: Peer educators are critical to the successful implementation of the behaviour intervention package. They should share some of the characteristics and life experiences of the

population with which they work. They should be knowledgeable about the challenges and stigma experienced by FSWs, as this knowledge fosters their credibility and promotes trust. Peer educators are a link between communities and instituted services, thereby facilitating participation of the FSWs community in interventions. Organisations/institutions conducting HIV prevention interventions for FSWs are required to invest in building the capacity of peer educators to achieve the goal of the National HIV prevention program for FSWs. It is therefore important that recruitment of peer educators be standardized.

- A sex worker operating in the hotspot/site of intervention
- A recognized member and leader in the FSWs community
- Acceptable to other members of the FSWs community
- Knowledgeable about the local sex work context and network
- Has a good social network in the site where she works
- Able to organise and conduct educational sessions/provide information
- Highly motivated to mobilise the FSWs community to protect itself
- Prepared to commit a certain amount of time to peer education activities
- Good listening, communication, and interpersonal skills
- Committed to being accessible to her/his peers in times of crisis

5.1.2. Peer educators' recruitment process: Peer educator recruitment should be conducted in a transparent manner, and it should provide equal opportunity for recruitment of all interested FSWs. The recruitment should occur after the entry-level activities are completed and before commencement of the intensive-level activities. Validation of the hotspots and clustering of the outreach sites will enable the organization/institution to estimate the number of peers needed and where they are needed. Sex workers who were met during mapping or initial outreach by the programme team and who meet the above-mentioned criteria should be encouraged to apply. Discussion should be held with all candidates about the role of peer educators, the commitment involved, reporting requirements, and the stipend to be paid.

5.1.3. Peer Educators' performance appraisal: A performance appraisal should be conducted every three months to determine how well the peer educators are performing, ie, number of contacts made, number of condoms distributed, number of referrals, and linkage to services. The review should be conducted with the Opportunity Gap Analysis tool, which enables peer educators to self-reflect and self-review. The organisations/institutions are encouraged to hold quarterly reflection meetings with the peers to get direct feedback on the project and peer educators' performance.

*5.1.4. Outreach and Peer Education activities***:** The role of peer educators during outreaches is that of building rapport and trust with the FSWs community and providing information about how to prevent HIV transmission and about available services. Peer educators also distribute condoms and lubricants, counsel clients on HIV prevention, and refer FSWs for behavioural and biomedical interventions. The educators' role also includes supporting peers to access legal aid and other clinical and non-clinical interventions during crisis, helping peers learn about their rights and entitlements and mobilising the FSWs community for collective action. These interventions increase the knowledge about HIV, reduce the prevalence of sexually transmitted infections, and increase condom use. For more information, please refer to the Peer Education Plus Manual for details about peer education in Nigeria, available online at http://www.sfhnigeria.org/The A to Z of the Peer.pdf.

The frequency of contact that peer educators make with peers will depend on the design of the project. Number of contacts between peer educators and peer(s) per week should be defined. During these contacts, educational information should be provided, condom use should be demonstrated, and condoms are distributed. Referrals should be made to relevant service delivery points and safe spaces where education and training sessions are held. During peer education and outreach activities, FSWs are:

- Provided information on HIV, sexually transmitted infection and reproductive health
- Shown how to use and are given male and female condoms and water-based lubricants
- Assessed for risk and referred for prevention and care services
- Counselled for risk reduction
- Provided support in crisis

*5.1.5. Risk reduction counselling and skills building***:** Risk-reduction counselling and skills building for risk reduction should focus on reducing HIV acquisition from oral, anal, and vaginal sex through correct and regular use of condom and lubricants with clients and other sex partners, appropriate douching procedures, management of dry sex, and substance use. Counsellors should also screen for those who need legal aid, mental health care, psychosocial support, and cancer screening services. These individuals should be referred for services. Counselling services should be provided in safe and private space, possibly in the clinics and drop-in centres. Counsellors should provide options to sex workers and encourage them to identify solutions to their problems. Risk-reduction counselling should follow these steps:

1. Conduct an initial and ongoing individual HIV, sexually transmitted infection, interpersonal/gender-based violence, mental health and cancer risk assessment.
2. Develop a personalized risk-reduction plan in collaboration with the FSW.
3. Refer for biomedical interventions (pre- and post-exposure prophylaxis, treatment of HIV and sexually transmitted infection, mental health and psychosocial support, cancer screening and management).
4. Monitor the progress of risk reduction routinely and modify/adjust the plan as needed.
5. Provide non-biomedical risk-reduction commodities (male/female condoms and lubricant).
6. Implement the personalized risk-reduction plan.
7. Routinely reinforce risk-reduction skills.
8. Identify other needs of FSWs and refer them to projects that can address the needs

5.1.6. Demonstration, promotion, and distribution of condoms, lubricants, and other commodities: Condom use is important for the prevention of sexually transmitted infections, including HIV. Demonstration, promotion, and distribution of female and male condoms, lubricants and other commodities, such as pre-exposure prophylaxis tablets, is important. Condoms, lubricants and other commodities should be made available and accessible at no charge. The correct and consistent use of condoms and lubricants should be encouraged. FSWs should learn how to negotiate the use of condoms with clients. Condoms, lubricants, and other HIV prevention commodities are freely accessible by FSWs through peer educators, outlets set up at hotspots, and clinics. Enough condoms should be made available to each FSWs, based on the estimated number of clients. Access and use of water-based lubricants during vaginal and anal sex should be promoted. Condom use should be free of coercion.

Chapter 6.0
IMPLEMENTATION OF BIOMEDICAL HIV PREVENTION PROGRAMMES

6.1. Biomedical Interventions

Biomedical interventions are the interventions that that directly influence the biological systems through which the virus infects a new host. Table 3 highlights the biomedical interventions to be provided to FSWs as part of a combination of HIV prevention packages.

Table 3. Programme Biomedical Interventions

Programme Component	Checklist of Activities for Implementation	Tools
BIOMEDICAL INTERVENTIONS		
STI control and Management Screening and treatment of sexually transmitted infections Sexually transmitted infection syndromic case management	**Entry level:** Identify sites where clinical services will be provided to FSWs Adopt the national standard operational guidelines for sexually transmitted infection management Advocate to relevant stakeholders and policymakers for inclusion of a budget line on biomedical intervention for FSWs Identify and build capacity of existing community structures to continue to implement community- based activities after project exit **Intensive level:** Train and retrain clinic staff on the use of the standard operational guidelines and procedures Provide risk-reduction counselling to all FSWs Refer and/or treat FSWs for sexually transmitted infection using the syndromic management Support partner notification and treatment Institute follow-up systems for FSWs managed for sexually transmitted infection in line with the national guidelines Strengthen linkages between community-level activities and health care facilities for sustainability	**Entry level:** Preference ranking Community mapping tool Facility mapping tool Facility assessment tool **Intensive level:** National STI syndromic management guidelines/tools

	Exit level: Strengthen linkages between community-level activities and health care facilities Institute forums for the continued engagement of community stakeholders with health facilities and FSWs groups, which that would review progress, feedback processes, and recommendations for sustainability	**Exit level:** Format/tools for referral linkages Format for referrals
Expected Results and Indicators Percentage of FSWs referred for sexually transmitted infection services Percentage of FSWs accessing sexually transmitted infection services		
HIV testing and counselling Mobile HIV testing services Facility-based HIV testing services Community-based HIV testing services HIV self-testing Referrals	**Entry level:** Adopt the national standard operating procedure guidelines for HIV testing services Identify organisations that can be linked to the programme to provide HIV testing services or train counsellors to provide the services. Establish linkages between HIV testing services providers and clinics that can provide HIV positive client with antiretroviral services, and HIV negative clients with pre-exposure prophylaxis services in the hotspots **Intensive level:** Follow-up of FSWs for regular testing and counselling Refer pregnant FSWs for HIV testing services Facilitate access of HIV-positive pregnant FSWs to prevention of mother-to-child transmission (PMTCT) services Promote community counselling systems and networks of people living with HIV **Exit level:** Linkages with positive network	Adapt national standard operating procedure tools
Expected Results and Indicators Percentage of FSWs referred for HIV testing services Percentage of FSWs counselled tested and received result Percentage of FSWs who tested HIV-positive		

PMTCT and sexual and reproductive health services HIV treatment, care, and support Reproductive health services, contraception and perinatal care **Allied services** Cancer screening Tuberculosis screening and management Viral hepatitis, diabetes, hypertension screening and management Mental health screening and psychosocial support Harm reduction services	**Entry level**: Follow/adapt the national standard operating procedure for treatment and care of FSWs **Intensive level:** Refer HIV-positive FSWs for PMTCT services and adhere to national PMTCT guidelines Provide/refer for adherence counselling Follow-up of HIV-positive FSWs by HIV-positive peers or acceptable outreach staff Promote PMTCT among FSWs as part of peer education package Refer FSWs for contraception Refer FSWs for cervical cancer, anal cancer, Human papilloma virus, and Herpes simplex virus 2 screening Refer FSWs for other health services screening such as hepatitis, diabetes, hypertension Refer FSWs for mental health support when needed Refer for harm reduction services when needed	Follow/adapt the national standard operating procedures for treatment and care of FSWs Adapt PMTCT guidelines Adapt tools from National Sexual Reproductive Health Adopt maternal and child health training tool
Expected Results and Indicators Percentage of pregnant FSWs referred for antenatal care Percentage of pregnant FSWs living with HIV receiving antiretroviral therapy Percentage of FSWs newly initiated on antiretroviral therapy Number of FSWs eligible for pre-exposure prophylaxis who receive it Percentage of FSWS receiving pre-exposure prophylaxis who seroconvert Number of FSWs eligible for post-exposure prophylaxis who receive it		

Biomedical intervention for FSWs can be provided directly by the implementing organization/institution or through referrals and linkages to clinical-care services. Biomedical interventions should be implemented by professionals, as defined in the national standard operation procedure guidelines. All linkage centres should be trained to be FSWs friendly. Biomedical intervention can be provided through site-based or mobile clinics.

Referrals can also be made to public and private health providers. All HIV-positive referred clients should be followed by a HIV-positive peer educator if the FSWs consents.

6.1.1. Sexually transmitted infections screening and treatment: The goals of sexually transmitted infection screening and treatment services for FSWs are identification, treatment, and prevention of the occurrence and transmission of sexually transmitted infections. Plans for management of sexually transmitted infections should be done in collaboration with FSWs at the clusters. The FSWs should be able to identify their preferred list of service delivery sites, barriers to service access, and ways to overcome the barriers. The workers should also identify the best mode of service delivery for them. Service delivery should be FSWs friendly and accessible at appropriate times for FSWs (such as late-night clinics). It should have infrastructure to provide confidential and comprehensive prevention, treatment and partner-notification services. Clinics providing sexually transmitted infection management services for FSWs should include the following in line with the WHO/National STI Guidelines:

- Health promotion and STI prevention activities, such as promotion of correct and consistent use of male and female condoms and water-based lubricants and other safe sexual practices;
- Provision of free male and female condoms, and lubricants, if available;
- Immediate diagnosis and clinical management of STIs;
- Provision of sexually transmitted infection medicines and directly observed therapy for single-dose regimens;
- Pre- and post-exposure prophylaxis for HIV;
- Health education and counselling for treatment compliance, correct and consistent use of condoms, and regular partner treatment;
- Quarterly check-ups, syphilis screening, and treatment of asymptomatic infections;
- Partner management programmes (contact referral. Includes clients and non-paying partners, such as boyfriends and husbands);
- Follow-up services for FSWs with STIs;
- Referral links to HIV counselling and testing centres, HIV care and support, and other relevant services;
- Linkages with outreach activities targeted at FSWs.

*6.1.2. Provision of HIV Testing Services***:** Clinical staff who provide HIV testing services should be trained on informed consent, privacy and confidentiality, and management of adverse outcomes of result disclosure. Provider-initiated HIV testing and counselling services should be provided to all FSWs who attend clinics for other services. HIV testing should be provided in line with the national HIV testing and counselling guidelines. HIV-positive FSWs should be referred for antiretroviral therapy or PMTCT services. Clients who do not use condom consistently or have repeated sexually transmitted infection should also be referred for pre-exposure prophylaxis. All FSWs are eligible for long-term HIV prevention and treatment support.

*6.1.3. Prevention of Mother-to-Child Transmission and provision of HIV treatment, care, and support services***:** The goal of HIV care and treatment is to restore the immune system, reduce HIV and AIDS-related morbidity and mortality, improve quality of life, decrease viral load, and reduce HIV transmission to partners of sex workers. HIV-positive sex workers must have access to a core package of HIV care and treatment services, which includes clinical assessment of disease stage, viral load assessment, CD4 count, co-trimoxazole prophylaxis, antiretroviral therapy, PMTCT for pregnant FSWs, management of opportunistic infections, and psychosocial support. A follow-up plan must be instituted for all HIV-positive FSWs to reduce the risk for poor treatment adherence and follow-up.

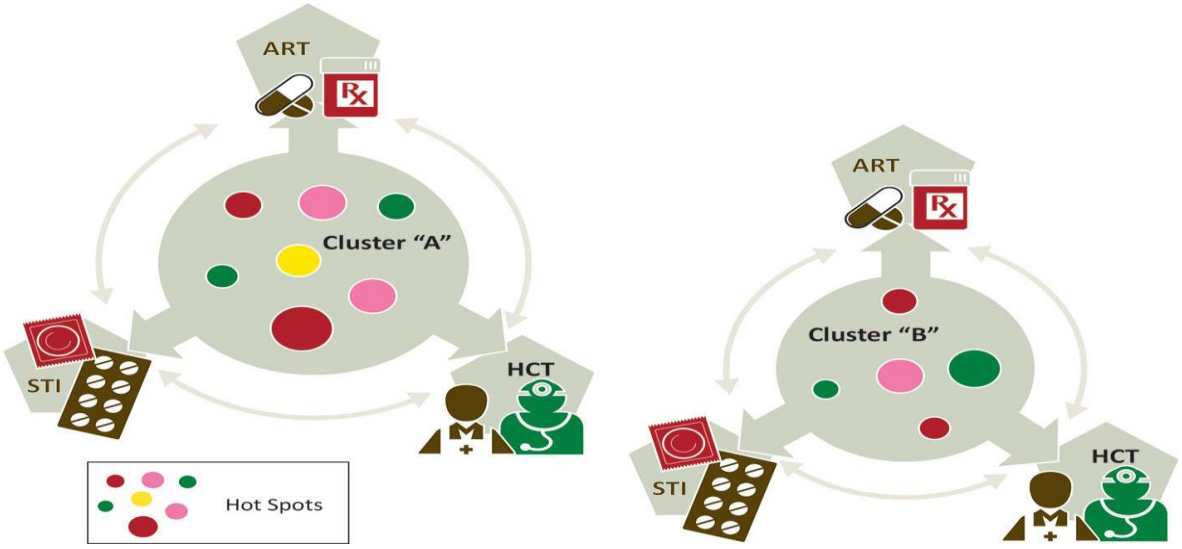
*6.1.4. Provision of Reproductive and Allied Health Services***:** Facilities should provide access to all forms of contraceptive methods and reproductive care including condoms, pregnancy screening, counselling and referral for other sexual and reproductive health services. Services to be provided directly or through referrals should

include medical and psychosocial services to rape survivors, those who face intimate-partner violence, and those with mental health challenges. In addition, linkages should be developed with organisations that provide economic empowerment services. FSWs should also be supported to access other allied services like tuberculosis screening and management, and viral hepatitis, diabetes, hypertension screening and management.

6.2. Cluster Approach to Service Delivery

Where there is a need to refer FSWs for biomedical interventions, appropriate local service-delivery organisations and institutions operating within the programme catchment area should be identified and partnered with. Figure 3 is a diagram depicting the "cluster" concept, with clusters of hotspots linked to a network of services within proximity to the hot spots.

Figure 3. "Cluster approach" for biological service delivery for female sex worker



The "cluster approach" involves the following key steps:

- List and characterize all FSWs hotspots identified at the implementation site
- Within each local government area, organise the FSWs hotspots into geographic "clusters" based on their proximity.
- List, describe, and map the health services delivery points available in the local government area hosting the project implementation site
- List and describe the available health services delivery points for each FSWs cluster. The list should be developed in consultation with FSWs community groups. This cooperation creates a list of service delivery referral points for the project.
- Identify key gaps in service availability within each cluster and address these gaps by recruiting/establishing new service delivery points.
- Train the service providers at identified referral clinics to be FSWs friendly and establish efficient referral system for FSWs to the service delivery points.
- Institute an active follow-up mechanism for all referred clients.
- In addition to the development of service delivery networks within each cluster, map other key service delivery points, including local police stations and social support organisations. Work with law

enforcement officials to support local HIV prevention programmes for FSWs and to mitigate the violence and harassment of FSWs.

Chapter 7.0

IMPLEMENTATION OF STRUCTURAL INTERVENTIONS TO REDUCE VULNERABILTY TO HIV

7.1. Structural interventions

Structural interventions address the critical social, legal, political, and environmental enablers that increase the vulnerability of FSWs to HIV infection and to sexual, physical, and emotional violence. The enablers also reduce the ability of FSWs to access HIV prevention services. The HIV risk of FSWs is heightened by societal and community factors, such as cultural norms, social marginalization, and criminalization, which limit their opportunities and access to services that could reduce their vulnerability. Structural interventions, aimed at reducing the vulnerability of FSWs, should focus on creating an enabling environment for improving their access to health services and commodities and for protecting their rights. Table 4 highlights the structural interventions to be provided to FSWs as part of a combination of HIV prevention package.

Table 4. Programme Structural Interventions

Programme Component	**Checklist of Activities for Implementation**	**Tools**
STRUCTURAL INTERVENTIONS		
Community mobilisation and dialogue Advocacy Access to justice Individual empowerment/incoming generating activities	**Entry level:** Analyse social, cultural, economic, and geographical context in with FSWs operate at target site Identify target sub-populations like adolescents and young FSWs, and FSWs living with disability Conduct stakeholder mapping and analysis Identify factors that promote stigma and discrimination, violence and exploitation of FSWs in the locality and by whom Prioritize key issues to be addressed and develop mitigation plan **Intensive level:** Engagement with FSWs community through awareness creation and dialogue Strengthen FSWs self-worth through life skills training, mental health and psychosocial support Engagement with community stakeholders for formal and informal policy change, institutional capacity	**Entry level:** Venue/community profiling tool Stakeholder analysis tool Risk and vulnerability assessment tool **Intensive level:** Crisis analysis tool Community Committees Tools for linkages for IGA programming

	development to support access of FSW to legal aid and justice. Improve access of FSWs to financial mitigation activities through partnerships with relevant public and private sector organisations and entities Adapt programmes to address the peculiar needs of adolescents and young FSWs, and FSWs living with disability **Exit level:** Development of sustainability plans Support possible formation of cooperatives of FSWs	**Exit level:** National peer education guide
Expected Results and Indicators Percentage of FSWs that report physical and/or sexual violence Percentage of FSWs that report stigma-related barriers to access health and/or social services Percentage of FSWs that report harassment and discrimination when accessing services.		

Some of these activities may be beyond the scope of services provided by the implementing organization/institution. In this case, the organization/institution can form partnerships with organisations that can provide the services and work with them to develop a comprehensive plan for the targeted area of work with FSWs. Structural interventions should include screening for violence, a common but poorly reported incidence faced by FSWs. Interventions should be provided to affected FSWs to prevent occurrences and address the mental health impact of exposures. Possible interventions include:

- Sensitization of law enforcement agencies to improve public health, including the health of sex workers.
- Training of FSWs' peers as paralegals to support FSWs who experience gender-based violence.
- Provide legal, psychosocial and medical support for victims of violence.
- Mobilise and sensitise FSWs on their rights and entitlements.
- Document experiences of violence.
- Medical management of sexual violence, such as access to post-exposure prophylaxis, emergency contraception, and/or post-trauma services.

7.2. Community Mobilisation and Dialogue

Community mobilisation is the process of engaging groups of FSWs in discussing, planning, implementing, and monitoring projects that affect them. Such engagement will increase the sense of ownership and build solidarity and support in the community of FSWs. The mobilization and dialogue-leading process should be delegated to a FSWs who is willing to take on the leadership role. Competency of the FSWs to play this role effectively should be built. The leadership role includes documenting, reporting, and acting as liaison between the sex-worker community and the legal system.

Liaisons should be trained on human-rights protection and reporting/redress mechanisms. Crisis-response teams should be constituted with the liaisons and other volunteers, and their capacity to respond promptly to crises that FSWs face should be built. Liaisons should also facilitate dialogue with other stakeholders, including the host community to promote a supportive and protective environment. Dialogues should be held with law enforcement agencies. to explore ways to mitigate the risk of violence for community members.

In addition, the project-implementation team should hold regular dialogues with stakeholders. FSWs should be encouraged to form cooperatives as a community economic empowerment strategy, and they should be encouraged to form community committees to discuss ways to improve the project and other issues.

7.3. Advocacy

The project, in collaboration with FSWs, should develop an advocacy plan with the aim of creating a supporting environment that reduces the risk of FSWs to violence and police harassment.

7.4. Individual Empowerment/Income-Generating Activities

FSWs should be given the opportunity to learn life skills and to have access to education so they can become economically independent through small-scale income-generating activities. The workers should also be provided access to financial mitigation through partnerships and linkages with public and private-sector organisations and entities. Drop-in centres can also be established to facilitate access to legal, psychological, medical support for victims of violence.

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Appendix A

Routine Monitoring Forms and Registers

The following forms are recommended for use for Key population HIV prevention intervention

S/N	Forms and Registers	Completed by whom
1	Recruitment form	Implementing partner Programme team / PE Supervisor
2	Peer session attendance form	Peer Educator
3	Peer Educators Monthly tracking form	Peer Educator
4	Peer Educator Supervisor's Monthly summary form	Community based organisation / Civil Society Organisation Staff
5	Quarterly PITT	Community based organisation / Civil Society Organisation Staff
6	Referrals forms	Peer Educator / Service provider / Person referred
7	Client summary form	Community based organisation / Civil Society Organisation Staff
8	Structural intervention tracking form	Community based organisation / Civil Society Organisation Staff
9	Structural monthly summary form (Income generation activity, Advocacy form, Community dialogue, Crisis management)	Community based organisation / Civil Society Organisation Staff
10	Condom distribution outlet register	Community based organisation / Civil Society Organisation Staff
11	Summary forms	Community based organisation / Civil Society Organisation Staff

S/N	NAME	ORGANISATION
1.	Mr. Alex Ogundipe	NACA
2.	Dr. Funke Oki	NACA
3.	Dr. Uduak Daniel	NACA
4.	Dr. Tolulope Oladele	NACA
5.	Mrs.Ezinne Okey-Uchendu	NACA
6.	Dr. Idoteyin Ezirim	NACA
7.	Mr. Kingsley Essomeonu	NACA
8.	Mrs. Hafsatu Aboki	NACA
9.	Mrs. Mercy Egemba	NACA
10.	Mr. Ajaja Olaleye	NACA
11.	Ms. Ajiboye Oluwatosin	NACA
12.	Mrs. Hasiya Bello	NACA
13.	Mrs. Roseline Akinola	NACA
14.	Dr. Salaudeen J.O	FMoH
15.	Samson Omoighe	NASCP
16.	Mrs. Ima John-Dada	NASCP
17.	Mr. Nduka Augustine	NDLEA
18.	Dr Uche Okoro	FACA
19.	Gabriel Undelikwo	UNAIDS
20.	Dr. Murphy Akpu	PEPFAR
21.	Dr. Abiye Kalaiwo	USAID
22.	Mr. Victor Adamu	CDC
23.	Adeolu Ogunrombi	WHO
24.	Dr Green Kalade	UoM
25.	Ejekam Ebuka	UoM
26.	Dr. Samuel Nwafor	UMB
27.	Dr. George Eluwa	Pop Council
28.	Mr. Toafeek Adeleye	AHF
29.	Aisha Omoh	SFH
30.	Segun Oyedeji	SFH
31.	Pat Igbene	SFH
32.	Berkisu Momoh	SFH
33.	Ngozi Ajaero	IHVN
34.	Francia Akolawole	IHVN
35.	Comfort Ige	IHVN
36.	Scott Adamu	APIN Public Health Initiative
37.	Olubunmi Amoo	APIN Public Health Initiative
38.	Akanji Micheal	HAI
39.	Dr. Ngozi Madubuike	NDLEA
40.	Enemo Amaka	KAP Secretariat
41.	Emmanuel Anene	ICTHARAE
42.	Helen Beyioku Alade	DldAN
43.	Anthony Nkwocha	PITCH

44.	Abah David Ali	LAPI
45.	Okiwu Henry .C	YouthRise
46.	Edward A Ogiji	APYIN
47.	Odizuru Onyebuchi	APYIN
48.	Patience Etim	Interperter
49.	Emmanuel Anene	KAP
50.	Patrick Enwerem	EVA
51.	Susan Kerma	KAP
52.	Winifred Mike-Ibe	SBCC TWG
53.	Patience Boniface	SBCC TWG
54.	Ibobo Daniel.B	SBCC
55.	Ibe Ifeanyi Amanze	SBCC
56.	Akpet Loretta Amba	SBCC
57.	Ajuk Francis Felix	SBCC
58.	Kelechi Igbojionu	Zinnok Initiative
59.	Prof. Morenike	Consultant